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Case Report

GIANT MUCINOUS CYSTADENOMA: CASE REPORT

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ABSTRACT
Mucinous tumours are the second most common type of epithelial ovarian tumours. Majority of these tumours are benign. However, some of these benign lesion can grow to enormous size, thus stimulating malignant neoplasia. This report presents the case of a 35 year old grand multiparous woman who came to our gynaecological clinic with 5 year history of abdominal swelling associated with weight loss. Abdomino-pelvic ultrasound scan revealed a large left ovarian cyst. She had laparotomy with left oophorectomy. A huge mucinous cystadenoma weighing 33.6kg was removed. Her post-operative course was unremarkable.

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INTRODUCTION
Mucinous tumours are the second most common type of epithelial ovarian tumours accounting for approximately 10-20% of these neoplasia[1]. About 75 85% of mucinous tumours are benign[2]. They are the largest tumour found in the human body[1]. The giant size and benign nature of this tumour in the present case informed the report.

Case Report
Mrs. I. H. a 35 year old para 7 + 1, 5 alive, last child birth 2 years and last menstrual period 3 weeks prior to presentation came to our gynaecological clinic with a five year history of abdominal swelling. The swelling started in the suprapubic region and progressively increased in size to occupy the entire abdomen. It was associated with weight loss and mild abdominal discomfort. She had no cough, vomiting or constipation. She also had no urinary symptoms. Her menstrual cycle and period were normal. Her past medical history was not contributory. She was the first in a polygamous family of 2 wives and had no formal education. Both the patient and her husband were farmers.

On examination, she was wasted and moderately pale. She was neither febrile nor jaundiced. The pulse, blood pressure and temperature were normal. The cardiovascular and respiratory systems were also normal. Abdominal examination revealed grossly distended abdomen which was tense and had visible peripheral veins. The abdominal girth was 120cm. The liver, spleen and kidneys were difficult to assess because of her tensed abdomen. On vaginal examination the vulva, vagina and cervix appeared normal. The size of the uterus and adnexa were similarly difficult t o assess because of her tensed abdomen. The pouch of Douglas was also tensed.

Abdomino-pelvic ultrasound scan revealed a huge thick walled non-septate cystic mass arising from the pelvis to the abdomen. The liver, spleen and kidneys were sonographically normal. The uterus was over shadowed by the cyst and could not be visualized per abdomen. However it appeared normal on vaginal ultrasound scan. The results of her electrolytes, urea and creatinine, urinalysis, liver function test and intravenous urography were normal. Apart from her packed cell volume of 20%, her full blood count was normal. Six units of blood were grouped and crossmatched for her and three units transfused preoperatively.

She had a laparotomy and operative findings were a huge ovarian cystic mass measuring 56cm x 52cm x 50cm and weighing 33.6kg, left hydrosalpinx, normal size uterus and grossly normal right ovary and fallopian tube. Omentum was adherent to the cyst antero-superiorly. There was no ascites and the liver, spleen and the intestines appeared normal. She had left oophorectomy and salpingectomy. The estimated blood loss 700mls and 2 units of blood were transfused intra-operatively. Her post-operative recovery was uneventful. Histology of the mass revealed mucinous cystadenoma.

Figure 1: **Mucinious Cystadenoma.**

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DISCUSSION

Majority of ovarian neoplasia, both benign and malignant arise from the ovarian surface epithelium and mucinous cystadenoma accounts for 10-20% of these tumours[1]. It tend to occur at relatively younger age than their malignant counterpart and is most common in women between 30-50 years of age[2]. It is unilateral in 90% and bilateral in 10% of cases[3]. The patient presented was 35 years old and had a unilateral tumour. Many benign ovarian tumours are asymptomatic. However, symptomatic ones tend to present with abdominal swelling and sometimes abdominal discomfort due to pressure effect as in this case. Presence of acute abdominal pain should raise the suspicion of torsion, rupture, infection or haemorrhage into the tumour[5]. Weight loss may suggest malignancy but some benign tumours like this case may have the symtom[2].

Clinical examination is usually tailored towards differentiating benign from malignant lesion. Apart from general examination the size, texture, consistency, tenderness and mobility of mass are assessed together with the presence/absence of ascites. Investigations like ultrasonography, chest x-ray, intravenous urography, barium studies, serum tumour markers and computerized tomography where indicated can be performed to exclude malignancy. The size of the tumour and history of weight loss warranted some of the investigations in the case presented. Clinical diagnosis may not be possible without a laparotomy and even then histological examination is essential for a confident conclusion. Pre-operative preparation should take into consideration the possibility of encountering a malignant lesion. Benign unilateral ovarian tumour can be managed by unilateral oophorectomy as in this case. In addition, the contralateral ovary should be examined and where it looks suspicious, a frozen section will assist in deciding whether to remove it or not. However the limitation of the frozen section (inability to assess the entire mass) should be borne in mind.

This case has demonstrated that not all giant ovarian tumours are malignant. Still every effort should be made to exclude malignancy in such tumours before offering conservative surgery.

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